Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROBERT RODRIGUEZ, MD
c/o GENEVA MEDICAL, INC
P.O. BOX 121589
ARLINGTON, TEXAS 76012

Respondent Name

HARRIS COUNTY

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-09-3412-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We seek full reimbursement of the outstanding balance of $150.00 along with interest accrued according to Rule 134.803..."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent's position is that its payments and reductions were appropriate. Additional reimbursement is not reasonable or necessary based on the documentation submitted for this medical dispute."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C., 912 S. Capital of Texas Hwy, Ste 300, Austin, Texas 78746-5242

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 08, 2008	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 25, 2008 with reimbursement of $100.00
   - W1A – Workers Compensation State Fee Schedule Adjustment
   - *Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202.*
   - Comments: PER THE DWCC-32 THE DESIGNATED DOCTOR WAS ONLY TO ADDRESS THE ASSIGNMENT OF IMPAIRMENT RATING. REIMBURSMENT IS 20% OF MAR REIMBURSEMENT.

   Explanation of benefits dated October 17, 2008 with reimbursement of $200.00
   - W3 – Additional payment made on appeal/reconsideration.
   - W1A – Workers Compensation State Fee Schedule Adjustment
   - *Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202.*
   - Comments: RE-CONSIDERATION OF EOB 907351 ALLOWING THE ADJUSTMENT OF $200.00 FOR THE ASSIGNMENT FOR THE IMPAIRMENT RATING.

   Explanation of benefits dated November 12, 2008 with reimbursement of $50.00
   - W3 – Additional payment made on appeal/reconsideration.
   - W1A – Workers Compensation State Fee Schedule Adjustment
   - *Reimbursement per Rule 134.204/134.204. Prior to March 1, 2008, Rule 134.202.*
   - Comments: RE-CONSIDERATION OF EOB 908750 ALLOWING THE ADJUSTMENT OF $50.00 FO THE TOTAL AMOUNT FOR THE IMPAIRMENT RATING REVIEW ONLY $350.00 TOTAL IN PAYMENT.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed the amount of $500.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned but was not requested by DWC on the EES-14 or DWC-32 forms. There is no reimbursement for MMI in this dispute. Review of the documentation supports that one body area was rated and listed as one unit in Box 24G of the CMS-1500.
2. Review of the narrative medical report shows that the DD used the Diagnosis Related Estimates (DRE) method. Therefore, per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using the DRE method on the knee (lower extremities) is $150.00. The respondent has already reimbursed the amount of $350.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 06, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.